APPLICANT PHYSICIAN ASSURANCES FOR J-1 VISA WAIVER APPLICATIONS

(Completion of this form satisfies the physician assurances required under U.S. Department of State regulations 22 CFR 41.63. Failure to complete this form will result in an application being deemed ineligible for a state recommendation for a J-1 visa waiver.)

The foreign medical physician requesting this J-1 visa waiver recommendation, through the health care facility identified in DPH form #43006, assures that each of the following statements are factual.

The applicant physician must initial each statement and must sign and date the bottom of this Applicant Physician Assurances form.

____ 1. I agree to the contractual requirements for J-1 visa waiver physicians set forth in federal immigration law at 8 U.S.C. 1184(l).

____ 2. I agree to provide primary medical services at the health care facility for a minimum of 40 hours per week, for a period of three years, and only in a federally designated shortage area (e.g., Health Professional Shortage Area or Medically Underserved Area).

____ 3. I hereby declare and certify that I do not now have pending nor am I submitting during the pendency of this request, another request to any United State Government department or agency or any State Department of Public Health, to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement.

____ 4. I agree to begin practicing at the health care facility within 90 days of the effective date of the J-1 visa waiver.

I, the applicant physician for whom the health care facility is submitting this application, do assure that each of these statements are factual.

NOTE: THERE ARE FEDERAL SANCTIONS FOR FAILURE TO COMPLY WITH THE IMMIGRATION AND NATIONALITY ACT REQUIREMENTS (see page 4 of the application guidance).

_____

Print Applicant Physician Name

_____ _____

SIGNATURE – Applicant Physician Date Signed